

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031171

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149Primary Registration District No. 1002Registrar's No. 4478

FILED SEP 14 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
1				
2 3928				
3				
4 1				
5 0				
6				
7 0				
8 0				
9 331 X				
10				
11				
12 65-0				
13				
		BY AFFIDAVIT OF		

USE BLACK INK

OR

TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in lb <u>54 yrs.</u>		Inside Limits <u>Yes</u> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7425 Madison</u>	
Reside on Farm <u>Yes</u> <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>J</u> Last <u>MAY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-89</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse--retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph Hospital</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>(Unknown) May</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Miss Ann DeCock</u>		Address <u>3206 Linwood</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>advanced arterio-sclerosis</u> DUE TO (c) <u>advanced glycos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 12 hrs</u> <u>? yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>Dec 1951</u> to <u>Aug 1962</u> and last saw ^{her} him alive on <u>Aug 29, 62</u> Death occurred at <u>12:00 midnight Aug 29-30, 1962</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. Paul Wright M.D.</u>	22b. ADDRESS <u>1324 Prof. Bldg</u>	22c. DATE SIGNED <u>Aug 30, 62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-1-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar</u>	ADDRESS <u>Woodland</u>	25. DATE RECD. BY LOCAL REG. <u>8-30-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

(Licensed Embalmer's Statement on Reverse Side)

Dr. Paul R. Wright
Prof. Bldg
Vi 2-1368

Thurs. 12:30 to 4:30

Get Today Sure!

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.